

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested: **Zinbryta® (daclizumab) Injection (Non-Preferred) (MEDICAID)**

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Dosage Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Quantity Limit – 1 ml per 28 days (0.036 ml per day)

CLINICAL CRITERIA: The following criteria **MUST** be met to qualify or authorization process will be delayed.

- Does the patient have a diagnosis of relapsing forms of Multiple Sclerosis (MS) (ICD-9 code = 340)? Yes No
 - If *No*, please provide diagnosis: _____
- Is the patient a minimum of 17 years of age? Yes No
- Has the patient tried and failed at least 2 or more MS drugs? Yes No

If *Yes*, list the drugs below in the space provided.
- Does the patient have a pre-existing hepatic disease or hepatic impairment? Yes No

(Zinbryta® is contraindicated in patients who have pre-existing hepatic disease or hepatic impairment.)

List pharmaceutical drugs attempted and outcome:

1. _____
2. _____
3. _____

MEDICAL NECESSITY: Provide clinical evidence that the preferred drug(s) will not provide adequate benefit:

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____